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Progress in making NHS efficiency savings

Summary

- 1** After a decade of sustained and significant growth, spending on the NHS is planned to increase by an average of 0.1 per cent in real terms in the four years from 2011-12 to 2014-15. At the same time, the NHS faces continuing growth in the demand for healthcare, due in part to the ageing population and advances in drugs and technology.
- 2** The Department of Health (the Department) has estimated that, to keep pace with demand and live within its tighter means, the NHS must make recurrent efficiency savings of up to £20 billion over the four-year period. This is equivalent to year-on-year efficiency savings of 4 per cent, or a cumulative saving of about 17 per cent. The Department expects the NHS to reinvest the savings to meet the demand for healthcare.
- 3** The NHS is seeking to make efficiency savings by focusing on four areas: quality, innovation, productivity and prevention (together known as QIPP). The Department considers that the NHS will have been successful in meeting the efficiency challenge if it continues to live within its budget and, as a minimum, maintains the quality of, and access to, healthcare.
- 4** Locally, the key players involved in delivering efficiency savings are as follows:

 - **Healthcare commissioners.** These currently comprise primary care trusts, which will be replaced by clinical commissioning groups and the NHS Commissioning Board from April 2013. Commissioners can make efficiency savings by reducing their own costs, securing the same services for a lower price, reducing the demand for services, or redesigning services.
 - **Acute, mental health and community service providers.** These comprise NHS trusts and NHS foundation trusts. Providers can make efficiency savings by reducing their own costs or redesigning services to achieve the same or better outcomes with fewer resources.
- 5** This report examines the progress in making efficiency savings in 2011-12 and whether the NHS is well placed to deliver savings over the three years, 2012-13 to 2014-15. Our audit approach is set out in Appendix One and our evidence base is outlined in Appendix Two.

Key findings

The Department reported that the NHS achieved almost all its forecast savings for 2011-12

6 The Department reported that the NHS made efficiency savings of £5.8 billion in 2011-12, virtually all of that year's forecast total of £5.9 billion. Just under half of the reported savings were made through the commissioning of acute services. In addition, the Department, its arm's-length bodies and strategic health authorities made an estimated £0.6 billion of savings (paragraphs 2.2 and 2.3).

7 Most of the reported savings were generated through contractual levers applied by the Department. To help support the delivery of savings, the Department reduced the national prices (tariffs) that primary care trusts pay to NHS trusts and NHS foundation trusts for healthcare by 1.5 per cent (4 per cent in real terms). NHS staff were also subject to the Government's two-year pay freeze for public sector workers from April 2011 (paragraphs 2.5 to 2.7).

However, there is limited assurance that all the reported savings were achieved

8 The chief executives of primary care trusts are required to confirm that the financial data they report, including on efficiency savings, is a true reflection of the actual and forecast position, but the Department does not validate or gain independent assurance about the data provided. The Department's analysis of national data provides assurance that a total of £3.4 billion of NHS efficiency savings and £0.6 billion of central savings were made (although these estimates do not take account of the cost associated with staff reductions, which amounted to at least £0.4 billion) (paragraphs 2.16 to 2.18).

9 Primary care trusts do not measure or report NHS efficiency savings in a consistent way, undermining the quality of the data. The Department has provided limited guidance, and as a result primary care trusts measure and report savings differently. For example, the costs associated with generating savings are not consistently deducted from the figures reported (paragraphs 2.8 to 2.10).

10 We estimate that up to £520 million of the reported savings for 2011-12 were non-recurrent (one-off in nature), meaning the NHS will have to find replacement savings in future years. The need for the NHS to make up to £20 billion of savings is based on the savings being recurrent. The Department does not monitor whether savings are recurrent or non-recurrent. Drawing on our survey data, we estimate that about 91 per cent of the savings reported by primary care trusts were recurrent and about nine per cent were non-recurrent (paragraphs 2.11 and 2.12).

The NHS was successful in living within its means

11 The NHS lived within its budget in 2011-12, although there was significant variation in financial performance, particularly among provider organisations.

The NHS as a whole reported a surplus of £2.1 billion, but 21 NHS foundation trusts and 10 NHS trusts finished the year with a combined deficit of £307 million. Some trusts in difficulty were given additional financial support from the Department, strategic health authorities and primary care trusts. In our report *Securing the future financial sustainability of the NHS*,¹ we concluded that it is hard to see that this approach will be a sustainable way of reconciling growing demand with the scale of efficiency gains required (paragraphs 2.20 to 2.24).

The NHS performed well against headline indicators of quality

12 In 2011-12, the NHS maintained or improved its performance against key indicators of quality. Performance standards for waiting times were achieved nationally and rates of healthcare associated infections continued to fall. Patient surveys indicated that the quality of patient experience was maintained or improved. The Department does, however, face a significant challenge in monitoring the quality of healthcare across the NHS as a whole. The existing indicators focus mainly on hospital care, and data to assess the quality of primary, community and mental health services in particular is limited (paragraphs 2.25 and 2.26).

The Department does not know whether demand is being managed in ways which inappropriately restrict patients' access to care

13 The NHS is making increased use of demand management measures to reduce the growth in hospital activity, but it is not clear whether the slowdown in growth is sustainable. Reducing demand and redesigning care pathways to make sure patients are treated in the most appropriate setting are key ways of generating efficiency savings. The growth in hospital activity was 1.2 per cent in 2011-12, compared with 3.7 per cent in 2010-11. Activity growth has been cyclical over the last 15 years (paragraphs 2.27 to 2.32).

14 The aim is to control demand without inappropriately restricting patients' access to care, but the Department has no way of routinely gaining assurance that this is being achieved. Through our survey, primary care trusts reported they had introduced a variety of measures to manage demand, in most cases for clinical reasons. Some stakeholder bodies have raised concerns, however, that access is being restricted. The Department has made clear that blanket bans on particular procedures are not permitted. It also told us that where it has been made aware of specific concerns, it has asked the relevant strategic health authority to investigate; these investigations have found that local commissioning decisions have been made in accordance with the established policies (paragraphs 2.33 to 2.37).

¹ Comptroller and Auditor General, *Securing the future financial sustainability of the NHS*, Session 2012-13, HC 191, National Audit Office, July 2012.

It will be increasingly difficult for the NHS to generate new efficiency savings in future years

15 Understandably, the NHS has started by making the easiest savings first.

The NHS benefited from the public sector pay freeze and action taken by the Department to control prices. It also adopted established ways of improving organisational efficiency, such as reducing back-office costs and the use of temporary staff (paragraph 3.3).

16 The savings made by NHS providers as a percentage of operating costs are increasing, but it is not clear what level of savings is sustainable over time.

In 2012-13, a third of providers plan to make savings of 5 per cent or more of operating costs but evidence suggests that year-on-year savings of more than 5 per cent have not been achieved in any other hospital sector (paragraphs 3.5 to 3.8).

Service transformation is key to making future savings, but only limited action has been taken to date

17 There is broad consensus that changing how health services are provided is key to a financially sustainable NHS.

Such changes will include integrating care, where multiple providers work together to provide a coordinated service for patients, and expanding community-based care. These measures are likely to reduce demand for acute hospital services (paragraphs 3.10 and 3.11).

18 Evidence indicates that the NHS has taken limited action to date to transform services.

There are a number of challenges to delivering service transformation. Changes take time to implement and may initially cost, rather than save, money. In 2011-12, the proportion of cash-releasing savings reinvested in transforming services varied and there is no evidence of a shift in staff from the acute to the community sector (paragraphs 3.12 to 3.16).

19 Financial incentives do not always encourage NHS providers to undertake service transformation.

The payment by results framework can create perverse incentives now that the NHS is seeking to reduce hospital activity; and in community settings, 90 per cent of care is reimbursed under block contracts, which do not provide an incentive to increase activity. The Department has introduced a number of measures, such as best practice tariffs, to incentivise service transformation and steps are also being taken at local level to address this issue (paragraphs 3.17 to 3.21).

20 There is a variety of support available to help the NHS generate efficiency savings, but there is a lack of evidence on the benefits of service transformation.

Differences in the quality and format of information between care settings mean commissioners may find it hard to compare the relative cost and quality of care in different settings or to convince stakeholders of the benefits of moving more services into the community (paragraphs 3.23 to 3.25).

21 The NHS reorganisation generated administrative savings in 2011-12 but uncertainty remains about who will be responsible for the oversight of efficiency savings at local level from April 2013. Clinical commissioning groups are already working with primary care trusts in planning savings, and strong clinical engagement is regarded as key to success. It is not clear, however, who will take over the role of strategic health authorities in overseeing savings plans and providing strategic direction for local health economies (paragraphs 3.27 to 3.29).

Conclusion on value for money

22 The NHS has made a good start and clearly delivered substantial efficiency savings in 2011-12. These savings will need to be maintained and built on if up to £20 billion is to be generated by 2014-15. For the NHS to be financially sustainable and achieve value for money in the future, it will need to quicken the pace of service transformation and make significant changes to the way health services are provided.

23 Our overall positive comments reflect the fact that this report covers the early stages of the drive to secure efficiency savings and the Department is still developing its approach. We have highlighted a variety of shortcomings in areas such as whether demand management is having positive or negative effects on access to healthcare; how service transformation can best be achieved; and the reliability of the reported savings data. Unless the Department takes action in these areas quickly, there is a risk that confidence will be undermined and the likelihood of success reduced.

Recommendations

Access to healthcare

- a** **The Department should take a more active interest in demand management and develop ways of gaining routine assurance that patients' access to healthcare is not being inappropriately restricted.** Monitoring access is not straightforward but the Department needs more evidence on the impact of demand management. It should also ensure that local policies on access to care are transparent so that commissioners can be held to account. For areas of concern, the NHS Commissioning Board should consider whether it would be useful to establish national access policies.

Supporting service transformation

- b** **The Department and the NHS Commissioning Board should work with the NHS to reduce barriers to transforming services, and evaluate the impact of transformation initiatives, as they are implemented, to generate evidence about what works locally and on a larger scale.** Better evidence is needed to convince stakeholders of the benefits of service transformation, to assess which changes are cost-effective, and to encourage the NHS to apply good practice more widely.

- c** In developing future mechanisms for paying for healthcare, the Department, Monitor and the NHS Commissioning Board should consider how these mechanisms can be used to drive service transformation and care that is integrated around the patient. Currently financial incentives do not always encourage providers to transform services or to work collaboratively with each other or with commissioners.
- d** The Department should develop better ways of monitoring progress on service transformation. Transformation comes in many different forms and progress is difficult to measure. Currently, NHS organisations report progress against project milestones but these can be achieved without the delivery of financial or other benefits. The Department should explore output measures that assess, for example, whether resources are shifting from hospitals to community services to provide a better indication of progress.

Reporting efficiency savings

- e** The Department should provide better guidance to the NHS on how to measure and report efficiency savings, so that the total savings reported are more strongly supported by robust data. Current reporting arrangements do not produce data that is either consistent for national reporting or useful to the organisations themselves. It is clear that not all the reported savings would meet our established criteria for assessing the validity of efficiency savings.
- f** The Department should improve transparency by making clear any caveats to data quality when it reports efficiency savings. The total reported for 2011-12 included non-recurrent savings and did not always take account of costs incurred in generating savings. Parliament and other users should be made aware of any data limitations and whether the data has been validated.

Oversight of efficiency savings

- g** The Department should clarify the arrangements for oversight of efficiency savings in the reformed NHS from April 2013. It is not clear who will oversee the efficiency plans of the new clinical commissioning groups. Neither is it clear who will make strategic decisions, for example on transforming services, that will benefit wider local health economies rather than individual NHS bodies.